SERIES EDITOR: Paulette Marie Gillig, MD, PhD

by RANDY A. SANSONE, MD; JOHN L. LEVITT, PhD; and LORI A. SANSONE, MD

Dr. R. Sansone is a Professor in the Departments of Psychiatry and Internal Medicine at Wright State University School of Medicine in Dayton, Ohio, and Director of Psychiatry Education at Kettering Medical Center in Kettering, Ohio. Dr. Levitt is the Director of the Eating Disorders Program at Alexian Brothers Behavioral Health Hospital in Hoffman Estates, Illinois and in clinical practice in Rolling Meadows, Illinois. Dr. L. Sansone is in practice (family medicine) with Premier HealthNet in Dayton, Ohio. Series Editor Dr. Gillig is Professor of Psychiatry with the Department of Psychiatry, Wright State University School of Medicine, Dayton, Ohio.

A Primer on Psychotherapy Treatment of Anorexia Nervosa in Adolescents

INTRODUCTION

Her parents brought her to the psychiatrist against her strong wishes. She was thin and looked frail, and they were exhausted from worry about her refusal to eat. The psychiatrist approached the adolescent, who insisted nothing was wrong, and said, "I'm here to help you. I know that you don't perceive it as help."

Like many psychiatric disorders, anorexia nervosa (AN) is a multidetermined disorder with diffuse symptomatology. Because of this, successful treatment requires an individualized yet integrated psychotherapy approach. In this article, we outline a fundamental psychotherapy strategy and illustrate how this might interface with other aspects of treatment. In presenting this approach, we emphasize that there are many variations of AN and that no single approach or intervention is consistently effective in all patients. Individualizing the treatment approach to each specific patient is of key importance for effective outcomes.

ADDRESS CORRESPONDENCE TO:
Randy A. Sansone, M.D., Sycamore Primary Care Center, 2115 Leiter Road, Miamisburg, Ohio 45342. Telephone: 937-384-6850. FAX: 937-384-6938. E-mail: Randy.sansone@kmcnetwork.org.

INITIAL EVALUATION

Psychiatric evaluation. The evaluation of a patient with AN includes both psychiatric and physical/metabolic assessment. For psychiatric assessment, the diagnosis of AN is based upon the criteria identified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*[1] and includes 1) the patient's refusal to maintain a weight at or above a minimally normal weight for age and height (i.e., 15% or more loss of weight expected for height); 2) intense fear of gaining weight or becoming fat; 3) body image disturbance, undue influence of body or shape on self-evaluation, and denial of the seriousness of the currently low body weight; and 4) at least three month's duration of amenorrhea in postmenarcheal patients.

AN is divided into two clinical subtypes, which are 1) the restricting type, in which there is no regular binge-eating or purging behavior, and 2) the binge-eating/purging type in which there is a regular pattern of clinical binge eating followed by some type of purging, such as self-induced vomiting and/or the use of laxatives, diuretics, or enemas.

Additional diagnostic supports include 1) a history of dieting behavior (e.g., persistent attempts to lose weight, mirror-gazing, preoccupation with clothing sizes, ritualistic eating, elimination of high-calorie foods from daily eating patterns, frequent weighing, and excessive body comparison of self to others); 2) a characteristic epidemiological context (i.e., female, adolescent, Caucasian, middle to upper socioeconomic strata); and 3) signs and symptoms related to the physiological effects of weight loss (e.g., hypometabolism characterized by slowed deep tendon reflexes, bradycardia, hypotension, delayed gastric emptying, constipation, cold intolerance, cessation of unnecessary bodily functions [e.g., menstruation], and lanugo). Height and weight assessment are essential as a number of individuals do not meet the explicit *DSM-IV* diagnostic criterion of 15 percent loss of initial body weight, yet suffer from subthreshold or subclinical cases of the disorder.

Following the confirmation of an eating disorder diagnosis, the assessment of other Axis I disorders, such as mood and anxiety disorders, would *seem* to be in order. However, the effects of weight loss and starvation make the assessment of some symptoms, such as anxiety and depression, which are inherently present in starvation states, extremely difficult to evaluate.[2] These symptoms are best re-evaluated following a reasonable degree of weight restoration (i.e., a body weight within 10% of the premorbid weight if the patient was not overweight prior to the onset of AN). Other types of Axis I symptoms, such as psychosis or obsessive-compulsive disorder accompanied by obsessions or rituals that do not entail food/body/weight themes, can be effectively evaluated but are substantially less prevalent in AN than anxiety and mood symptoms.

Personality. As in all psychiatric assessments, Axis II evaluation should be considered. However, the young age of these patients as well as starvation and its related symptomatology often compromise effective evaluation. According to empirical studies, the diagnostic subtype of AN appears to have some predictive value with regard to Axis II features.

KEY POINT: Varying Traits and Disorders

Individuals with the restricting type of anorexia nervosa frequently have comorbid obsessive-compulsive personality traits or disorder, while those with the binge-eating/purging type (i.e., characteristics consistent with impulsivity) are more likely to suffer from borderline personality traits or disorder.[3]

Physical evaluation. All patients with AN should undergo a physical examination with a determination of height and weight, cardiac examination, and laboratory studies. Further cardiac evaluation (i.e., electrocardiogram, event monitor) may be necessary if the initial examination or the patient's history suggest or indicate problems with cardiac functioning. According to the *Practice Guideline for the Treatment of Eating Disorders (Revision)*,[4] recommended routine laboratory studies include a blood urea nitrogen, creatinine, complete blood count with differential, thyroid assessment, and electrolytes. For those patients with amenorrhea of one year's duration or more, Dual Energy X-Ray Absorptiometry (DEXA scan) should be considered to evaluate for bone loss/osteoporosis.

"It is vital to let the parents, who are often the ones bringing the adolescent AN patient to treatment, know that you understand their worries, fears, and psychological exhaustion."

INDIVIDUAL PSYCHOTHERAPY TREATMENT

Treatment entry. In our experience, adolescent patients with recent-onset AN are highly resistant to entering into a treatment. While the disorder is multidetermined, the resulting symptomatol-

ogy functions similarly in nearly all cases to develop and maintain an isolated inner world that perpetuates the illusion of personal control while being devoid of meaningful relationships with others. So while there are many adaptive functions associated with AN (e.g., the need to sustain a developmental arrest for psychological reasons, fears of sexual development, emaciation to deter sexual abuse, and creation of personal crisis to engage parents or peers),[5] the condensed function of AN is the development and preservation of an alien existence that is disconnected from the pain and disappointments encountered in the real world.

KEY POINT: The Treatment Challenge of Patient Resistance

The function of AN is to develop and maintain an isolated inner world that perpetuates the illusion of personal control while being devoid of meaningful relationships with others and, therefore, disconnected from the pain and disappointments encountered in the real world.

Treatment threatens the illusive safety of this complexly constructed inner world, exposing the patient to the very realities that he or she attempted to escape from in the first place through the development of symptoms. In conjunction with body-image distortion (i.e., the inability to accurately detect the extreme level of weight loss), patient resistance is inevitable. As a result, psychological insight is very low or non-existent in AN, and adolescent patients are typically forced into treatment by parents. Understandably, the patient perceives the treatment providers as external threats—as adversaries who will force the patient to gain weight. To the patient, this is unacceptable. Low weight is the cornerstone of his or her illusionary world. All thoughts and behaviors align with the pursuit of low weight, and these time-consuming symptoms create the daily world of the sufferer.

PRACTICE POINT: Addressing the Patient's Resistance to Treatment

Given these negative attitudes towards treatment, developing a therapeutic alliance with the patient is a genuine challenge. In our experience, a therapeutic interface can be facilitated by being *absolutely* honest with the patient about the treatment, validating the problematic symptoms related to the disorder (e.g., fatigue, sleep difficulties, continual cold intolerance, reduced efficiency of thinking, social isolation, loneliness), and candidly acknowledging the "at-odds" relationship dilemma that exists between the patient and the therapist. The therapist might address this by stating, "I sincerely realize that it doesn't appear this way, but I *really* am here to help you. It's hard for me to be in a role where my help is not understood." It is also important to emphasize to the patient that the therapist must act in a responsible manner and may be forced to undertake seemingly unacceptable interventions to save the patient's life. "Please understand that I will not let you die and that I may have to suggest things that you oppose." We believe that verbalizing and sharing this complex relationship dilemma (i.e., "I'm here to help you, but I know that you don't perceive it as help") validates its reality and disperses the ambivalence about the therapeutic relationship from the patient throughout the entire treatment team.

As various therapeutic relationships are initially being established with the patient (e.g., patient/therapist, patient/psychiatrist, patient/dietitian, patient/primary care physician), simultaneous attention is paid to medical evaluation and treatment, determination of the appropriate treatment environment (i.e., inpatient, partial hospitalization, outpatient treatment), strategy for weight restoration, and the integration of psychotropic medications if indicated. When possible, treatment team participants should consider group supervision sessions or, at the very least, team meetings to coordinate and consolidate a unanimous management philosophy for each patient.

INITIAL PHASE OF PSYCHOTHERAPY TREATMENT

During the initial phase of psychotherapy treatment, patients with AN tend to be detached, defensive, exhausted, and intellectualizing. The psychopathology and accompanying starvation process seem to remove any semblance of emotions and feelings from these young patients. Their inner world seemingly functions according to complex and unemotional rules and guidelines.

"...nearly all [AN patients] develop and maintain isolated inner worlds that perpetuate the illusion of personal control while being devoid of meaningful relationships with others."

KEY POINT: Beginning with Cognitive-Behavioral Intervention

Given this clinical scenario, it is impractical to begin psychotherapy treatment with an emotion-based intervention (e.g., psychodynamic psychotherapy). The initial recommended psychotherapy intervention is cognitive-behavioral, and the emphasis in this approach is cognitive restructuring. In addition, ongoing supportive psychotherapy is

essential in developing and maintaining a therapeutic relationship.

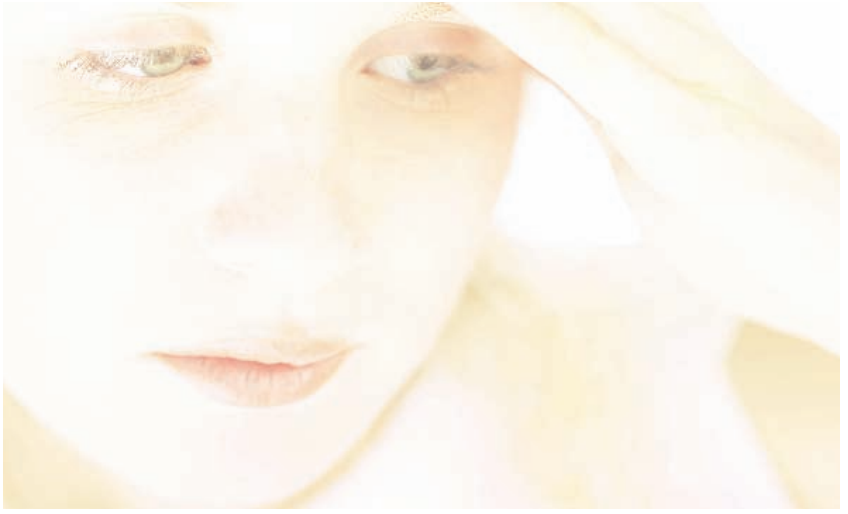
PRACTICE POINT: The Use of Cognitive Restructuring

Cognitive restructuring is based upon eliciting faulty thought patterns from the patient and using logic to correct them. Within the framework of anorexic thinking, there are unending distortions around food, body, and weight issues. Examples include the beliefs that losing weight is good and gaining weight is bad; there are good foods and bad foods; losing weight will make one more popular; and being thin is being successful and in control.

Using cognitive restructuring, the therapist attempts to elicit the preceding cognitions and then systematically challenges them in a logical and intellectual manner. For example, after elicitation, the therapist might respond, "You believe that losing weight is good, but you are in a hospital with a heart monitor. I understand that you periodically slip into arrhythmias. How can that be good?" As another example, "You said that losing weight would make you more popular. Over the past few months, how have your friends related to you? Do you feel closer to them?"

With cognitive restructuring, the therapist takes a non-forceful position, so as not to threaten the patient's sense of control. The therapist simply and unobtrusively questions the genuine reality basis for the patient's belief system, step by step.

In our experience, the process of cognitive restructuring continues throughout the entire treatment, but is most present at the outset and during the initial period of weight restoration. At some point in the weight restoration process, biological stress recedes and the patient begins to experience a return to premorbid personality functioning. At this juncture, it is reasonable to shift to the next phase of individual psychotherapy while continuing cognitive restructuring and supportive psychotherapy.



SECOND TREATMENT PHASE: Adding a Psychodynamic Approach

During the second phase of treatment, cognitive restructuring and supportive psychotherapy may now be augmented with an exploratory, psychodynamic approach that examines the various factors that may have contributed to the development of AN. By teasing out the adaptive functions of the disorder, both the patient and therapist can begin to dialogue alternative coping strategies and life paradigms.

KEY POINT: Appreciating the Role of Developmental Arrest in AN

For example, developmental arrest in AN may serve as a functional solution for the patient that effectively delays or even eliminates adulthood and its perceived demands.

After some extensive psychotherapy work, the therapist may conclude that one contributory factor to the patient's symptoms is an obsessive-compulsive personality style, which magnifies the perceived responsibilities of adulthood. In his or her rigid and unwavering efforts to secure high grades, perform superbly at the piano, and excel in cross country, the patient concludes that he or she is barely able to meet these demands as a young adolescent. Indeed, meeting these demands with a perfectionistic approach is exhausting. The patient concludes that, "If this is what it is like in adolescence now, how could I possibly survive the demands of adulthood?"

PRACTICE POINT: Helping the Patient Overcome an Obsessive-Compulsive Personality Style

The therapist can begin to work with the preceding dynamics by pointing out the unrealistic demands that the patient places upon him- or herself. "You know, you really expect exceptional things out of yourself. I sense that this is longstanding and related to your perfectionism and the need to out-perform others." This therapeutic conclusion can be illustrated with working examples in the patient's life. "You consistently maintain a 3.9 grade average. How many of your peers are able to do that? And as for cross country, what percent of your races did you win last year?" The therapist can validate that it would be difficult to maintain this level of stamina in adulthood, and that in reality few can. "It must take an incredible amount of energy to be so good at

all of these things. Few people are able to do such things." Because of the limitations of this approach to adulthood, the therapist can suggest alternative approaches and introduce the concepts of priorities, personal choice, and the importance of leisure. "You only have so much juice in the battery! It might be helpful to think about how much energy you really want to spend on these activities, so that you can grow in other areas as well as take a break sometimes." This approach enables the therapist to continually validate the patient's dilemma and re-examine issues.

FINAL PHASE OF PSYCHOTHERAPY: Reconnection

In the final phase of psychotherapy treatment, reconnection is the essential theme. Again, AN is an isolating lifestyle. The disorder typically emerges in adolescence and often results in a developmental suspension due to periods of extreme starvation. In effect, the chronological 18 year old before you may actually be functioning at the psychosocial level of a 15 year old. Because of this, the therapist must focus in the final phase of psychotherapy treatment on reconnection. Psychotherapy techniques are varied and consist of interpersonal, psychodynamic, and supportive approaches as well as problem-solving interventions and continuing cognitive restructuring.

Reconnection entails many themes. Initially, peer reconnection is an important theme. While the patient has been in the hospital, day treatment, residential treatment, and/or intensive outpatient treatment, peers have been dating, attending school dances, seeking employment, and considering what colleges to attend. It is quite natural for patients to feel and believe that they no longer fit with their premorbid peer group. This may cause a great deal of anxiety, which is typically translated into food and body issues.

PRACTICE POINT: Helping the Patient Understand the Underlying Dynamics of her Food/Body Issues

In the following vignette, the patient has recently been discharged from the hospital. Several friends have invited her to a football game and a meal afterwards at a local chain restaurant. The patient begins, "They asked me to go out to eat after the football game. I was scared. Really scared. I didn't know what to tell them! Will they notice that I have gained weight? Will they think I'm fat? Will they watch me eat? What am I going to eat in a place like that, anyway?"

The therapist might respond, "You know, these are really very valid issues. This is your first social outing since hospitalization, isn't it? Before we get to the specifics, though, I want to know what it's like for you to get together with your friends."

In this example, the therapist validates the food/body issues, but attempts to get beneath them to determine other eventful issues. For many patients, underlying anxieties, fears, and stresses are systemically translated into eating disorder symptoms. In the role of a translator, the therapist must begin to re-translate this language. To what might this emerging eating disorder cognition relate? What is the patient *really* experiencing? This translation process must be undertaken without appearing to dismiss the patient's concerns.

Reconnection may also relate to dealing with teachers and the school environment, planning for college, strategizing around dating, and sorting out personal needs and feelings and successfully communicating them to others. Many of these individuals have developed externally accommodating adaptations that belie their underlying oppositional and resistant nature. At either end, whether accommodating or opposing, there is no genuine negotiation of personal needs and feelings.

KEY PRACTICE POINTS

- **An individualized psychotherapy approach is of fundamental importance in the treatment of AN.**
- **Psychotherapy treatment in AN tends to proceed in phases.**
- **Cognitive restructuring is the initial psychotherapy intervention in AN.**
- **During the mid and late phases of psychotherapy treatment, the foci include the adaptive context of AN in this particular individual as well as reconnection with others.**
- **Group psychotherapy also entails a phase-based strategy.**

PRACTICE POINT: Helping the Patient Learn Better Assertiveness Skills

In the following vignette, the patient's mother has advised her to consider a private, competitive college. "I don't know what to do! I guess I could just go and let my eating disorder explode! But, if I don't go, she'll be mad at me." The therapist might respond, "I know that your mother's advice is important in making a decision, but I really need to understand how *you* feel about these college options. What do you believe *you* need in a college?" Subsequently, the therapist helps the patient to tease out her college choices and disclose them to her mother, rather than directly challenge her mother's specific suggestion.

The preceding example also illustrates the importance of enhancing assertiveness skills in patients with AN. Assertiveness is an ongoing theme in treatment, especially during the phase of reconnection. It is particularly important in the arena of dating. Assertiveness interfaces with a variety of interpersonal issues, including the expression of feelings and needs, establishment of boundaries, and decision-making. Without some degree of assertive-

ness and empowerment, one's experience in an interpersonal relationship will feel manipulative and exploitative. Therefore, these issues must be sorted out prior to the resumption of dating.

FAMILY PSYCHOTHERAPY

As in individual psychotherapy, we favor a multiphase strategy with a symptom-management perspective for the family treatment of AN. This approach occurs in three phases. The initial phase is forming an alliance, the second phase revolves around teaching intervention, and the final phase focuses on dealing with family issues.

Alliance. The first phase is focused on developing an alliance (i.e., "joining") with the family and assessing the family system as it pertains to the eating disorder.

PRACTICE POINT: Connecting with Parents and Family

It is vital to let the parents, who are often the ones bringing the adolescent AN patient to treatment, know that you understand their worries, fears, and psychological exhaustion.

The therapist might indicate this by saying, "It has to be scary having a child who appears so thin and frail," and/or, "I imagine that you are feeling at your wit's ends not knowing exactly what to do or how to respond to your child's eating disorder." Families can be reassured by the therapist's clarification that, "The good news is that, in my experience, if we are able to work effectively as a team, most patients get better." Time is spent defining the family "team" and understanding how the family functions and responds to AN. This will provide the substrate for intervention in the second phase.

Teaching intervention. The second phase focuses on actively working with the family to intervene in the AN process itself. A particular focus in this phase is to empower parents to set up appropriate rules, guidelines, and standards regarding healthy behaviors, which include positive consequences for successfully meeting them as well as limits for when they are not met. For example, the therapist might comment, "Your daughter is refusing to eat; what do you think is an appropriate consequence for a child who refuses to follow her parents' guidelines?" Or "If your daughter had diabetes and refused to take her insulin, how would you respond?" The goal with this approach is to get the relevant family members active and involved in directing recovery, not merely responding to AN. There are, of course, many possible techniques for doing this and others have suggested a comprehensive family approach similar to this.[6]

Dealing with family issues. The third phase of family psychotherapy is designed to focus on other family issues that may be present. Some of these may be marital issues that have gone long unattended or issues related to the developmental stages of the family. For example, some families have a very difficult time with their children leaving home and becoming independent adults. While these struggles are common in many families, in AN families they may serve to either maintain or perpetuate the disorder. In any case, it may be necessary to address these for successful treatment.

GROUP PSYCHOTHERAPY TREATMENT

Group psychotherapy is often part of an overall regimen of treatment for the AN patient and follows a similar multiphase approach, with the initial phase focusing on support, the second phase dealing with relationships, feelings, and skills, and the final phase centering on the patient exploring relationship issues.

Support. Group psychotherapy is typically educational and supportive in nature during the early phases of treatment when the AN patient is psychologically and physically compromised. In this stage, groups should be encouraging and supportive of the patient's desire for recovery, yet directive. As mentioned earlier, a cognitive-behavioral focus may be most useful when group members gently examine participants' distorted thinking around food, weight, and recovery, and support each other in challenging the ambivalence toward recovery.

Educational groups that teach specific information can also be useful at this phase of treatment. For example, giving specific information that is databased around health,

"The therapeutic strategy is to get patients to limit their acting out of symptoms and to carefully examine what the symptoms might mean in the context of their current life situation."

nutrition, and the effects of the AN can be extremely helpful, especially in conjunction with the groups described above.

Relationships, feelings, and skills. In the second phase of treatment, group psychotherapy may focus more on relationships, feelings, and skills for daily functioning that are more broadly useful in recovery. For example, social skills groups help the AN patient manage his or her anxiety in social situations and/or enhance assertive behaviors, which may be extremely productive. Examples of other types of groups for eating disorder patients have been described elsewhere.[7]

Exploring the dynamics of relationships. The third phase of group psychotherapy is most useful when the AN patient is physically and psychologically stabilized and functioning. In these groups, the patient might explore significant relationship issues and their accompanying dynamics. Of course, these groups may be more emotionally intense and require a more functional patient. These groups are often more dynamic and emotive in nature.

PRACTICE POINT: Strategies for Dealing with Symptom Reemergence and Relapses

Most, if not all, patients experience brief symptom relapses during their recoveries. Because of this, the therapist needs to actively plan for relapses. As a relapse strategy, patients need to view symptoms as markers of underlying and unmanaged conflict. Being a consistent and unwavering marker for eating disorder patients, symptoms actually function as a fairly reliable indicator that "something is wrong." The therapeutic strategy is getting patients to limit their acting out of symptoms and to carefully examine what the symptoms might mean in the context of their current life situation. This approach is an excellent relapse strategy because it distracts from symptoms and highlights solutions.

For example, in response to a recent symptom exacerbation, the therapist might query, "You seem to be getting pretty restrictive with your eating behavior again. Above and beyond the eating disorder symptoms, what is going on with you?" The patient responds, "I just feel fat. Really fat!" The therapist counters, "I understand that you feel that way, but something is probably driving these symptoms. What is it?" The patient continues to resist, "I don't really know. I just know that I hate Spanish." The therapist responds, "What do you mean?" The patient explains, "I'm getting a B in that class and it sucks." Now the therapist and patient have reached beneath the symptoms and determined their genuine etiology. The goal is to teach the patient to consistently utilize this approach to symptoms as well.

CONCLUSION

Following careful psychiatric and physical evaluation, the psychotherapy treatment of AN proceeds in overlapping phases. These phases are timed with the patient's physical condition as well as psychological growth. While the techniques vary from therapist to therapist, initial support, validation, education, and cognitive restructuring are common to most. These approaches are subsequently supported by interventions that explore the adaptive context of the eating disorder as well as facilitate the identification and negotiation of feelings and needs with others. While all of these themes are common in most treatment undertakings, we wish to emphasize the importance of individualizing interventions to each unique patient. We believe that this overview of psychotherapy treatment likely represents the tip of the iceberg with regard to day-to-day work with AN patients. These patients are extremely challenging, yet their personal growth is immensely rewarding.

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